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ABSTRACT

Selected Department of Defense (DOD) policies were examined concerning nurse anesthetists, nurse midwives, and nurse practitioners, particularly in regard to the extent to which these nurse specialists are allowed an independent scope of practice in military hospitals and the degree of physician supervision they require. Discussions were held with nurses' and physicians' associations and appropriate DOD and military service officials and specialty advisers. In addition, regulations were examined and data obtained on the number and ranks of nurse specialists. DOD directives require the supervision of nurse specialists by physicians in the appropriate specialty area (e.g, obstetrics), with the degree of supervision depending on the nurse specialist's training, education and experience. Nursing organizations also expressed concerns about military nurse specialists' promotion and input to DOD policy. It was found that promotion to lieutenant colonel or commander and higher ranks may involve supervisory or management responsibility, but personnel in those ranks will also continue to do clinical work in their specialties. Following the letter summarizing the review and its findings, the following appendices are provided: (1) supervision and scope of practice for nurse specialists; (2) services' regulations on supervision of nurse specialists; (3) career issues of concern to nurse specialists; (4) nurse input on policy issues; and (5) comments from DOD (acceptance letter). A table provides data on nurse specialists by military rank. (KM)

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United States General Accounting Office

GAO

Report to the Honorable
Daniel K. Inouye, U.S. Senate

March 1989

DOD HEALTH CARE

Issues Involving Military Nurse Specialists

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GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-233032

March 29, 1989

The Honorable Daniel K. Inouye
United States Senate

Dear Senator Inouye:

In your letter of December 21, 1987, you stated that various private sector nursing organizations had expressed concern that military nurse specialists are not being accorded the administrative and clinical responsibilities that their training justifies. In subsequent meetings, your staff asked us to examine selected Department of Defense (DOD) policies concerning three kinds of nurse specialists: nurse anesthetists, nurse midwives, and nurse practitioners. A key issue involved the extent to which these nurse specialists are allowed an independent scope of practice in military hospitals and the degree of physician supervision they required. Your staff requested that we (1) contact several nursing organizations to clarify their concerns about these and other aspects of military nursing and (2) clarify DOD as well as Army, Navy, and Air Force policies concerning scope of practice and supervision.

In response to this request, we spoke with officials representing the American Nurses' Association, the American College of Nurse Midwives, the American Association of Nurse Anesthetists, and the American Association of Colleges of Nursing. The concerns expressed by these organizations were then discussed with officials from the Office of the Assistant Secretary of Defense for Health Affairs; the chiefs of each service's nursing corps; and specialty advisers[1] for nurse anesthetists, nurse midwives, and at least one type of nurse practitioner in each service. To obtain the physicians' perspective, we discussed each concern raised by the nursing associations with representatives of the American College of Obstetricians and Gynecologists, the American Society of Anesthesiologists, and the American Medical Association. We also (1) examined DOD and service regulations that relate to the issues raised and (2) obtained data from the services on the number and ranks of nurse specialists.

[1]Nurse specialists are represented at the service level by nurse specialist advisers. These advisers, who are expected to be knowledgeable about the issues and concerns of the specialist group they represent, serve as consultants to the services' surgeons general. Although the roles of advisers vary somewhat among the services, all provide advice to the surgeons general concerning policies and other issues affecting nurse specialist groups.

Nurse Specialists in the Military

Each of the services—the Army, Navy, and Air Force—uses a variety of nonphysician health care providers. Among these providers are nurse anesthetists, nurse midwives, and nurse practitioners—specialists who have received additional training beyond that of registered nurses and who possess a high degree of knowledge, skill, and competence in a specialized area. In fiscal year 1987, DOD had 1,211 such specialists on its rolls: 611 nurse anesthetists, 68 nurse midwives, and 532 nurse practitioners (see table 1).

Table 1: Active Duty Nurse Specialists in the Military Services (Fiscal Year 1987)

Specialty	Army	Navy	Air Force	Total
Nurse anesthetist	244	116	251	**611**
Nurse midwife	23	6	39	**68**
Nurse practitioner	219	58	255	**532**
Total	**486**	**180**	**545**	**1,211**

Nurse specialists are individually privileged or authorized to perform specific functions (e.g., initiate, alter, or terminate medical care regimens) within established medical protocols and service guidelines (see pp. 10-12). Nurse anesthetists are trained in the administration of anesthetics. Nurse midwives are trained to handle low-risk and uncomplicated gynecological and obstetrical care of women and the delivery of newborns. Nurse practitioners are trained to provide primary health care services in such areas as adult medicine, family practice, obstetrics and gynecology, and pediatrics. These nurses provide (1) advanced nursing services to clients with complex and multiple needs and (2) medical services in collaboration with physicians and other health care providers. In 1987, one or more of the services were utilizing nurse practitioners in adult medicine, family practice, obstetrics and gynecology, pediatrics, and primary care.

Summary of Findings

As a matter of practice, DOD physicians are ultimately responsible for the care provided to patients in military medical treatment facilities. For this reason, a health care provider who is a nonphysician may not practice totally independent of a physician. This is in keeping with the Joint Commission on Accreditation of Healthcare Organizations' standard which states that each patient's general medical condition is the responsibility of a qualified physician member of the medical staff (see p. 10).

DOD Directive 6025.2 (Nov. 17, 1983) caused the private sector nursing organizations much consternation because of its references to supervision of nurse specialists by physicians. According to the nurses' associations, this directive could, if strictly implemented, unnecessarily limit the scope of practice of military nurse specialists. Further, these associations believe that nurse specialists should be assigned to nursing departments within a medical facility and be supervised by nurses.

On November 17, 1988, DOD canceled this directive and issued a quality assurance directive, which included a section on nonphysician-physician relationships. Although no specific reference was made in this new directive to the supervision of nurse specialists, DOD officials informed us that nurse specialists will continue to be supervised by physicians who have appropriate privileges. For example, nurse midwives can be supervised by any physician who is privileged to practice obstetrics. The degree or closeness of the supervision provided will depend on the nurse specialist's education, training, and experience. According to DOD, this is the manner in which supervision has been traditionally provided in service hospitals. Further, according to many specialist advisers, the scope of practice of military nurse specialists currently may be greater than the scope of practice their counterparts in the private sector are granted (see p. 8).

As of December 22, 1988, the services had not changed the wording of their regulations that require physician supervision of nurse specialists. At that time, DOD officials did not know whether any changes would, in fact, be made. Appendix II provides more detailed data concerning the services' policies relating to the supervision and scope of practice of nurse specialists.[2]

The American College of Obstetricians and Gynecologists and the American Society of Anesthesiologists believe that a physician's supervision of, or delegation of functions to, a nurse specialist should be based on mutually agreed upon written medical guidelines/protocols (nurse midwives and nurse practitioners) or an individual's education, training, and demonstrated skills (nurse anesthetists) (see pp. 9-10).

Other issues raised by the private sector nursing associations involved military nurse specialists' promotions and their input to DOD policy. The nursing organizations were concerned that nurse specialists could not be promoted to the higher ranks and continue to perform clinical duties.

[2]These policies are currently aligned with the recently canceled DOD Directive 6025.2.

According to DOD officials, nurse specialists who are promoted to the rank of lieutenant colonel (Army and Air Force) or commander (Navy) and higher ranks may be required to assume supervisory or management responsibilities in their specialties. In most instances, however, they will also continue to do clinical work within their specialties (see app. III).

The nursing organizations also believe that nurse specialists do not have adequate input to proposed DOD policies that may affect them. DOD officials stated that the services are given an opportunity to provide input on all proposed policies affecting nurse specialists. Proposed new policies are submitted to the Secretaries of the Army, Navy, and Air Force, who then request input as appropriate. The services do not have a formal process by which they receive input from nurse specialists. But service officials say they use the specialty advisers to review and comment on any proposed policy affecting the scope of practice of a nurse specialist group. Specialty advisers told us that efforts by the services to obtain their input have been satisfactory (see app. IV).

In June 1988, we briefed your staff on the results of our work and, at its request, have prepared this report summarizing the information we obtained. DOD was provided the opportunity to comment on a draft of this report. On February 15, 1989, the Assistant Secretary of Defense (Health Affairs) informed us that DOD found the report to be factual and had no further comment (see app. V).

As arranged with your office, we plan to send copies of this report to DOD and the services. In addition, copies will be made available to others on request.

The major contributors to this report are listed in appendix VI.

Sincerely yours,

David P. Baine

David P. Baine
Director, Federal Health
Care Delivery Issues

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Abbreviations

DOD	Department of Defense
GAO	General Accounting Office

Supervision and Scope of Practice: Nurse Specialists

The degree of supervision a Department of Defense (DOD) physician provides to a military nurse specialist and the type of work assigned (i.e., scope of practice) is dictated by professional standards of practice;[1] the knowledge, training, and education of the nurse; and the needs of the patient. DOD seeks accreditation for its hospitals from the Joint Commission on Accreditation of Healthcare Organizations,[2] and thus adheres to the Joint Commission standards of practice. One of these standards requires that a physician be ultimately responsible for the outcome of a patient's medical care. No mention is made in these standards of the degree to which nurses should be supervised.

When asked by GAO to identify their specific concerns about the supervision provided and scope of practice permitted military nurse specialists, the American Association of Colleges of Nursing, the American Nurses' Association, the American Association of Nurse Anesthetists, and the American College of Nurse Midwives all discussed the wording in DOD Directive 6025.2 as it pertained to the supervision of nurse specialists by physicians. In their opinion, the references to supervision in that directive could result in the provision of more supervision to military nurse specialists than they believe is necessary, thus restricting their scope of practice. Most of the specialty advisers we interviewed in DOD do not believe this is occurring and stated that the military nurse specialists' scope of practice may, in fact, be broader than that of their civilian peers. The issue was addressed at the DOD level with the cancellation of this directive on November 17, 1988. Service regulations still, however, require physicians to provide supervision to nurse specialists (see app. II). As of December 22, 1988, DOD did not know whether any or all of the services intended to modify their regulations as a result of the cancellation.

Nursing Organizations' Concerns About Scope of Practice and Supervision

Representatives of the major private sector nursing organizations told us that nurse specialists in the military may be having unnecessary limitations placed upon their scope of practice by DOD. They were particularly concerned about the provisions in DOD Directive 6025.2,[3] which made reference to the supervision of nurse specialists by physicians. In their opinion, such provisions, if strictly implemented, could lead to

[1] Agreed-upon levels of excellence or established norms.

[2] A private organization that establishes standards hospitals must meet in order to obtain its seal of approval in the form of accreditation.

[3] This directive was canceled after our discussions with representatives of the nursing organizations.

unnecessary restrictions on the scope of practice of nurse specialists. Further, these representatives objected to the assignment of nurse specialists to medical departments within a hospital. In their opinion, military nurse specialists should be supervised and evaluated by a nurse in that specialty—not a physician—and these specialists should be under the administrative direction of the nursing department in a hospital. In addition to the overall concern about levels of supervision and their potential impact on a nurse specialist's scope of practice, some organizations objected to certain Joint Commission standards as well. The American College of Nurse Midwives informed us that the Joint Commission standard requiring that physicians promptly evaluate patients admitted to inpatient services by nonphysician members of a medical staff is an unnecessary level of physician oversight for certified nurse midwives. Further, representatives of the American Association of Nurse Anesthetists stated that they believe the Joint Commission standards pertaining to anesthesia services are susceptible to an interpretation that would allow DOD to restrict the scope of practice of nurse anesthetists (i.e., require that nurse anesthetists be supervised by anesthesiologists) if it chooses to do so. For example, one standard states that the care of patients who receive services is the responsibility of licensed independent practitioners with appropriate clinical privileges. In the Association's opinion DOD could, if it chose to do so, define licensed independent practitioners as anesthesiologists only. Further, the Association believes that the services are considering a regulation to do just that—require that nurse anesthetists be supervised only by anesthesiologists. At present, service regulations require supervision by an anesthesiologist, but only if one is available.

Physicians' Views on Supervision of Nurse Specialists

Physicians' organizations that represent the interests of anesthesiologists, obstetricians, and gynecologists believe that a physician (1) is ultimately responsible for his or her patient's care and (2) must be able to assert authority as necessary to assure that appropriate medical care is provided. The anesthesiologists and obstetricians/gynecologists have written position papers on the delegation of functions to nonphysician personnel.

The American Society of Anesthesiology guidelines state that delegations of functions to nonphysician personnel should be based on specific criteria (i.e., individuals' training, education, and demonstrated skills) approved by the medical staff on the recommendation of the physician

responsible for anesthesia care. The guidelines also state that the functions performed by nurse anesthetists should be under the personal direction of an anesthesiologist or other qualified physician.

A Joint Statement of Practice Relationships Between Obstetrician/Gynecologists and Certified Nurse Midwives states that it is critical that obstetrician/gynecologists and certified nurse midwives have a clear understanding of their individual, collaborative, and interdependent responsibilities. Further, quality of care is enhanced when the two professions work in a relationship of mutual respect, trust, and professional responsibility. The statement notes that the physical presence of a physician is not necessarily required when care is being given by a certified nurse midwife. But the maternity care team should be directed by a qualified obstetrician and gynecologist.

DOD's and Services' Policies on Supervision and Scope of Practice

DOD adheres to Joint Commission standards in order to assure that its hospitals maintain their accreditation. Thus, as a matter of practice, its physicians (1) are responsible for the outcome of a patient's care and (2) provide nurse specialists with whatever level of supervision the physicians believe necessary.

Joint Commission standards specifically state that each patient's general medical condition is the responsibility of a qualified physician member of the medical staff. But these standards make no mention of the type and degree of supervision a physician should provide a nonphysician in carrying out this responsibility. Conversely, before its cancellation, DOD Directive 6025.2 (Nov. 17, 1983) included explicit language pertaining to the role of nurse specialists and the supervisory relationship between DOD physicians and nurses. Some of the provisions included in this directive were as follows:

- Nurse specialists must function under a specific listing of duties, responsibilities, and limitations.
- A physician must be appointed in writing to supervise and review the patient care of each nurse specialist provider in those duties involving the potential to determine, start, or alter a regimen of medical care.
- To evaluate care provided by the nurse specialist, the physician supervisor must review, at least monthly, a minimum of 20 percent of the

patient records prepared by a nurse specialist and document that he or she (the supervisor) has made that review.[4]

- No more than three health care providers who are nonphysicians may be supervised and reviewed by a single physician.
- Nurse specialists will not be granted admitting authority.

In November 1988, DOD Directive 6025.2 was canceled. None of the aforementioned statements on the roles of nurse specialists, supervision, or limitations on nurse specialists' privileges were carried forward in the directives that now deal with peer review and clinical supervision.[5] DOD Directive 6025.11, DOD Health Care Provider Credentials Review and Clinical Privileging (May 20, 1988), requires privileging of certain health care providers, including nurse specialists. The privileges are to be based on an individual's education, training, and experience.[6] Further, the directive lists nurse anesthetists, nurse midwives, and nurse practitioners among providers who may need clinical supervision. But the directive does not specifically state who should provide that supervision and with what degree of frequency or level of intensity. DOD Directive 6025.13, DOD Medical Quality Assurance (Nov. 17, 1988), states that

"... all individually privileged health care personnel shall be considered members of the medical and dental staff for peer review and patient care assessment purposes. The medical staff or dental staff shall recommend uniform standards of care and criteria for use in assessing quality of care, and shall perform peer review and patient care assessment."

Although there is no reference to supervision in the new directives, DOD officials informed us that they will be interpreted as follows: As a matter of practice, and in keeping with Joint Commission standards, DOD physicians are ultimately responsible for the care provided to all patients. Therefore, a physician will still be involved in the evaluation and monitoring of care provided by nurse specialists and will provide

[4]Directive 6025.2 also required DOD physician supervisors to perform and document by signature any review of a nonphysician's patient care. However, in March 1984, DOD revised the policy to require DOD physician supervisors to provide written evaluations of their reviews of nonphysicians' patient care.

[5]Clinical supervision includes giving good health care, seeking assistance when needed, and requesting appropriate referral for patients when necessary.

[6]Privileging is the process of evaluating each provider's formal education, training, clinical experience, and evidence of physical, moral, and ethical capacities, when making recommendations with regard to the providers' competence to treat certain conditions and perform certain medical procedures (e.g., deliver babies).

them with whatever supervision he or she deems necessary. Nurse specialists will, however, be allowed a full scope of practice for their specialty, limited only by their education, training, and experience. In these officials' opinions, this is the manner in which supervision has traditionally been provided in service hospitals, and the nurse specialists' scope of practice has not been impaired.

While DOD has eliminated reference to supervision in its directives, service regulations still contain explicit provisions for physician (1) supervision of nurse specialists, (2) review of patient records prepared by nurse specialists, and (3) cosigning of written orders on inpatients by nurse midwives and nurse practitioners. At this time DOD does not know whether the services will revise these regulations to make them more compatible with the new DOD directives.

Specialty Advisers' Positions on Supervision and Scope of Practice in the Military

Each service has several nurse specialty advisers who serve as expert consultants to the service's surgeon general. These advisers are expected to be knowledgeable about the issues and concerns of the nurse specialist group they are representing. Most of the 11 specialty advisers we interviewed expressed no major concern about the scope of practice given nurse specialists. Some, in fact, said the scope of practice in their services may be broader than that of their civilian counterparts. All advisers did, however, object to the wording in DOD's recently canceled Directive 6025.2. The advisers stated that the language in this directive was often vague and left to interpretation by those attempting to implement it. Thus, implementation could be as loose or as stringent as the interpreter wanted to make it. For example, the directive did not differentiate between the supervision to be provided nurse specialists—who are privileged and have extensive specialized training—and general duty staff nurses—who are not privileged and have limited specialized training. In essence, the directive allowed an interpretation that all nonphysician providers required the same level of monitoring by a physician. The advisers believe that nurse specialists should be subjected to less supervision than a general duty nurse and this should be reflected in the regulations.

Specific scope of practice concerns unique to individual specialties or services are discussed in the following sections.

Nurse Anesthetist Advisers

Nurse anesthetist advisers in the Army are of the opinion that organizations representing anesthesiologists are trying to convince DOD and the services to change their regulations and require nurse anesthetists to be supervised only by anesthesiologists. We discussed this with Army officials, who stated that they had received recommendations to make such a change from anesthesiologist consultants, but are not actively considering doing so. Current service regulations require an anesthesiologist to supervise nurse anesthetists, but only if one is available; when an anesthesiologist is not available, each service can make provisions for alternative physician supervisors (see app. II).

The Army and Navy advisers were also concerned that, without physician approval, nurse anesthetists in their services cannot discharge patients from the post-anesthesia recovery unit. Both services require a physician to countersign discharge orders written by nurse anesthetists because, in the opinion of Army and Navy officials, the physician is ultimately responsible for the outcome of the medical care provided.

Nurse Midwife Advisers

Nurse midwife advisers in the Navy and Air Force informed us that they object to the provision in DOD Directive 6025.2 which stated that DOD nonphysician health care providers will not be granted admitting authority. Both the Army and Air Force requested and received an exception from DOD, giving their nurse midwives admitting authority within their scope of practice. Restrictions were, however, placed on this admitting authority, thus allowing compliance with Joint Commission standards. Specifically, the Air Force requires an obstetrician to see and evaluate all obstetric patients within 24 hours of admission. Likewise, the Army requires that an obstetrician evaluate patients in person some time during the prenatal period. Navy officials stated that although they did not request an exception to this requirement from DOD, nurse midwives in the Navy can admit patients with a physician's authorization.

The provision restricting midwives' admitting authority was eliminated when DOD Directive 6025.2 was canceled, and it has not been incorporated in any new directives.

Nurse Practitioner Advisers

A nurse practitioner adviser in the Navy objected to the fact that nurse practitioners specializing in obstetrics and gynecology had their authority (privilege) to deliver babies removed in 1985. In her opinion, when the Navy changed its policy, the nurse practitioners who were already

delivering babies should have been allowed to continue to do so. According to DOD and Navy officials, nurse midwives are better trained and qualified to deliver babies and, therefore, should be the only nurses granted this privilege.

Departmental Assignment of Nurse Specialists

Private sector nursing association personnel believe that in order to be treated equitably, military nurse specialists should be assigned and accountable, both administratively and professionally, to nursing departments within each service, not to medical departments or staff. Further, in their opinion, nurse specialists should be supervised by nurses and allowed to practice according to standards defined by the nursing profession, not standards defined by physicians. The associations are concerned that military nurse specialists are being assigned to medical departments and evaluated by physicians on the basis of physician standards instead of nursing standards.

According to DOD officials, DOD does not have a policy (1) regulating how nurse specialists should be assigned to a department within a medical treatment facility, or (2) stating who should be responsible for nurse specialists (that is, a nursing or medical department). But each service has its own policies and procedures in this area. Specifically, a nurse specialist in the Air Force or Navy is assigned, as a member of the hospital staff, to the department of his or her specialization; for example, a nurse midwife is assigned to the department of obstetrics and gynecology. Therefore, these nurses are under the supervision and authority of the chief of the department and are viewed as a resource for that department. For all career matters, however (such as authorizations to attend educational seminars, selection for special assignments, and promotions), nurse specialists are under the authority of the department of nursing within a medical treatment facility.

According to Air Force and Navy officials, the rationale for the assignment of a nurse specialist to the department of his or her specialization is that the scope of practice of a nurse specialist differs from that of a general duty staff nurse; therefore, nurse specialists are assigned according to the privileges granted to them as patient care givers within a medical treatment facility. The department of specialization accepts responsibility for the evaluation of care provided by these nurses. The physician supervisor monitors the care and is also charged with preparing the nurse's officer efficiency ratings ("reports") with input from

others.[7] Air Force and Navy officials advised us that although there is no written policy, in practice, nursing department (for example, the chief of nursing) input is included in the ratings of these nurse officers.

In the Army, a nurse specialist is assigned to the nursing department and then detailed to the department of his or her specialization. He or she is given both a physician supervisor and a nursing supervisor. The rating process, according to Army officials, for these nurse officers must include input from superior officers who (1) have knowledge of the day-to-day practice of the officer being rated and (2) practice in the same field of specialization (such as pediatrics or obstetrics). In the final analysis, however, the commanding officer of the medical treatment facility decides who shall be responsible for completing the ratings for these nurses; as stated in written policy, the chief of nursing provides recommendations to the commanding officer as to what supervisors should be included in the rating process.

Specialty advisers generally were satisfied with the manner in which nurse specialists were assigned to a department. For example, one Air Force adviser stated that, in her opinion, the Air Force procedure helps to foster good relationships between nurse specialists and physicians. An Army adviser supported her service's procedure by stating that nursing departments maintain control over both nurse specialists and general duty staff nurses; this, in her opinion, allows for better working relationships between the two groups of nurses.

[7]Ratings are formal written evaluations of performance completed by senior officers.

Services' Regulations on Supervision of Nurse Specialists

Nurse Anesthetists

Army	Supervision is to be provided by a military physician of the same specialty. When none are available, a civilian physician of the same specialty should be appointed. If a physician of the same specialty is not available, then another type of physician is appointed and a formal exception through channels is requested. Normally, an anesthesiologist may not supervise more than three nurse anesthetists. In facilities where there is only one anesthesiologist available to supervise four or more nurse anesthetists, he or she may do so. A monthly review of patient records prepared by nurse anesthetists is required, and the number of records to be reviewed is determined by the supervising physician. Preanesthesia orders written by nurse anesthetists are countersigned by a physician before anesthesia can be administered.
Navy	Supervision is to be provided by an anesthesiologist, if available. If not, it is to be provided a surgeon. A physician may not supervise more than three nurse anesthetists except in geographically remote areas and deployed units. A weekly review of patient records prepared by nurse anesthetists (no specified percentage) is required, except in geographically remote areas, where it can be performed every 6 months. Orders written by nurse anesthetists on inpatient medical records must be cosigned by a physician.
Air Force	Supervision is to be provided by an anesthesiologist, if available. If not, it is to be provided by the chief of surgery. No physician-to-nurse anesthetist ratios for the purposes of supervision are specified. A weekly review of a representative sample of patient records prepared by nurse anesthetists must be completed by the supervising physician.

Nurse Midwives

Army	Supervision is to be provided by a military physician of the same specialty. When none are available, a civilian physician of the same specialty is appointed. If a physician of the same specialty is not available,

	another type of physician is appointed and a request for a formal exception made through channels. A physician may not supervise more than three nurse midwives. A monthly evaluation of patient records prepared by nurse midwives is required, and the number of records to be reviewed will be determined by the supervising physician.
Navy	Supervision is to be provided by a physician within the department of obstetrics and gynecology. A physician must not supervise more than three nurse midwives, except in geographically remote areas and deployed units. A weekly review of patient records prepared by nurse midwives (no specified percentage) must be completed by the supervising physician, except in geographically remote areas, where it can be performed every 6 months. Orders written by nurse midwives on inpatients shall be cosigned by a physician.
Air Force	Supervision is to be provided by the chief of obstetrics and gynecology. No physician-to-nurse midwife ratios for the purposes of supervision are specified. A weekly review of a representative sample of patient records prepared by nurse midwives must be completed by the supervising physician.

Nurse Practitioners

Army	Supervision is to be provided by a military physician of the same specialty. When none are available, a civilian physician of the same specialty is appointed. If a physician of the same specialty is not available, then another type of physician must be appointed and a request made for formal exception through channels. A physician may not supervise more than three nurse practitioners. A monthly review of patient records prepared by nurse practitioners is required, and the number of records to be reviewed will be determined by the supervising physician.
Navy	Supervision is to be provided by a staff physician in the department to which the nurse practitioner is assigned. A physician may not supervise more than three nurse practitioners, except in geographically remote areas and deployed units. A weekly review of patient records prepared by nurse practitioners (no specified percentage) must be completed by

the supervising physician, except in geographically remote areas, where it can be performed every 6 months. Orders written by nurse practitioners on inpatient records are to be cosigned by a physician.

Air Force

Supervision is to be provided by a physician adequately credentialed to provide supervision. No physician-to-nurse practitioner ratios for the purposes of supervision are specified. A weekly review of a representative sample of patient records prepared by nurse practitioners is required. Orders written by nurse practitioners on inpatient records are to be counter-signed by the supervising physician.

Career Issues of Concern to Nurse Specialists

Career issues—including the promotion of nurse specialists, the wartime roles of nurse midwives, and pay disparities between nurse anesthetists in the public and private sectors—were raised by one or more private sector nursing organizations with whom we met. We discussed each of these issues with service personnel; as could be expected, each group brought a different perspective to the issues involved.

Promotions to Higher Rank

Representatives of private sector nursing organizations told us that in order for a military nurse to achieve the rank of lieutenant colonel (Army or Air Force) or commander (Navy), he or she must move into an administrative position. In the organizations' opinions, a nurse specialist should not have to make such a transition in order to get promoted. According to DOD officials, whether such a transition is required depends on service policy. Specifically, a nurse specialist in the Air Force can be promoted to lieutenant colonel or colonel and still maintain his or her clinical role. According to Air Force officials, nurse specialists at higher ranks should have more than clinical responsibilities and should be taking leadership roles. But the Air Force needs experienced, practicing nurse specialists, and currently the only significant reward available to encourage their retention is promotion.

It is unusual for either a nurse midwife or nurse practitioner to continue to practice exclusively as a clinician in his or her area of specialization at the rank of lieutenant colonel and colonel, noted Army officials. The Army expects officers at these ranks to assume supervisory and administrative responsibilities. Officials pointed out that on promotion, these nurses would not move entirely out of their particular specialty, but would assume a different role. For example, a nurse midwife would be acting in a supervisory or administrative role within the discipline of obstetrics and gynecology.

Navy officials said their nurse specialist officers can and do get promoted to commanders and captains while serving in clinical roles. To advance to these ranks, however, especially captain, the nurse specialist may have to assume additional administrative or supervisory responsibilities.

Using the latest available data at the time of our review, the number of nurse specialists at the rank of lieutenant colonel and colonel (Army and Air Force) or commander and captain (Navy) are shown in table III.1.

Table III.1: Nurse Specialists by Military Rank

	Rank[a]				
	01-02	03	04	05	06
Nurse anesthetists:					
Army	1	92	124	41	6
Navy	0	36	61	16	0
Air Force	19	149	95	17	2
Nurse midwives:					
Army	0	3	12	4	0
Navy	0	1	2	2	0
Air Force	1	20	22	6	1
Nurse practitioners:					
Army[b]	11	92	118	23	0
Navy	1	11	26	11	5
Air Force	4	64	135	51	4

Source: Services' manpower and personnel offices.

Note: Army data as of June 1988; Navy data as of April 1988; Air Force data as of fiscal year 1987, including those in training status.

[a]In the Air Force and Army, ranks are second lieutenant (01), first lieutenant (02), captain (03), major (04), lieutenant colonel (05), and colonel (06). In the Navy, the equivalent ranks are ensign (01), lieutenant junior grade (02), lieutenant (03), lieutenant commander (04), commander (05) and, captain (06).

[b]Actual numbers reflect nurses with this specialization as an additional skill indicator. Army data indicated not all these nurses are currently assigned duty in this specialty. Nurses are allowed to hold up to three codes—primary code (e.g., medical/surgical nurse) and two skill codes.

Contingency Roles

According to the American College of Nurse Midwives, military nurse midwives do not have a wartime contingency role in their specialty area. DOD and the services agree with this but stated that in wartime, both nurse midwives and nurse practitioners will mobilize as general duty staff nurses.

According to Air Force and Navy officials, even though there is no defined wartime contingency role for nurse midwives and nurse practitioners in their specialties, some of them would be deployed in their specialties (i.e., obstetric and gynecological nurse practitioners); others would be utilized in other capacities with the expectation that some of their specialty skills would be utilized (i.e., assessment, assisting with surgical cases, and triage).[1] According to Army officials, these specialists would mobilize as general duty staff nurses, and their specialty

[1]The allocation of treatment to battle and disaster victims according to a system of priorities designed to maximize the number of survivors.

skills would be utilized in much the same manner as in the Air Force and Navy.

Nurse practitioners and nurse midwives in the Army are periodically assigned to tours of duty outside their specialties, but they usually remain within their field areas of expertise (for example, a nurse midwife would stay in obstetrics and gynecology, acting as a supervisor on an obstetrics and gynecology service within a hospital, but he or she would not diagnose and treat during this tour of duty). This assignment policy does not apply to nurse anesthetists since their specialty has a defined wartime contingency role. The rotation of assignments assures that nurse practitioners and nurse midwives maintain skill proficiency for their mobilization roles as general duty nurses. Army officials recognized that this assignment policy could result in the loss of some specialty expertise, but did not think this sufficiently detrimental to override the advantages of such a policy. Air Force and Navy policies do not require such alternate assignments.

Retention of Nurse Anesthetists

The American Association of Nurse Anesthetists believes that pay disparities between the private sector and the military make it difficult for the services to retain experienced nurse anesthetists. DOD and service officials agree that the pay disparity between civilian and military nurse anesthetists is a problem, and believe it has an impact on both recruiting and retention. Currently, the Congress is considering legislation that would make bonus pay available for military nurse anesthetists.

According to the Navy's specialty adviser and cognizant Navy officials, additional retention problems in their service may exist because of the amount of time male nurse anesthetists are deployed on board ships. DOD policy states that no women are to be assigned to combat ships. This policy is the result of the Women's Armed Services Integration Act of 1948 (section 210, Military Duty).

Nurse Input on Policy Issues

According to the nurses' associations, nurse specialists do not have adequate input on DOD's and the services' policies affecting them. According to DOD officials, policy development affecting military nurse specialists' practices is a participatory process. In developing directives and other policy guidance, DOD requests comments from the Secretaries of the Army, Navy, and Air Force; each, in turn, is responsible for channeling the request to the service's surgeon general and other appropriate departments or officials. On occasion, DOD also requests input from various outside professional organizations and, in many instances, from nurses retained on the staff of DOD's quality assurance offices.

According to service officials, there are no written policies requiring input by nurse specialists on policies affecting them. Each surgeon general has an adviser for each specialty, however, who represents his or her specialty and is charged with a variety of responsibilities, including acting as consultants on policy matters. In these officials' opinions, specialty advisers are given adequate opportunity to comment on policies that affect the practice of nurse specialists, and recent efforts by DOD to obtain input from the services on these policies have been satisfactory.

According to most specialty advisers, their input is solicited and used by the services but less so in DOD.

Comments From the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

HEALTH AFFAIRS

15 FEB 1989

Mr. Lawrence H. Thompson
Assistant Comptroller General
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Thompson:

This is the Department of Defense (DoD) response to the General Accounting Office (GAO) draft report, "Issues Involving Nurse Specialists in DoD", dated January 11, 1989 (GAO Code 101340/OSD Case 7879).

The DoD has reviewed the report, found it to be factual and has no further comment. The Department appreciates the opportunity to review the report in draft form.

Sincerely,

Excellent job!

Bud Mayer

William Mayer, M.D.

Major Contributors to This Report

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